ROBERT J. WIRTZ, D.D.S.
Specialist in Orthodontics

Member American Association of Orthodontists

MEDICAL AND DENTAL INFORMATION

ADULT GENERAL INFORMATION

Date _____

Patient's Name _____ (Last / First / Middle) Home Phone (_____) _____

Age in Years _____ Date of Birth ____/____/____ (Mo / Day / Yr) Sex M F Height _____ Weight _____ Single _____ Married _____ Divorced _____ Separated _____

Home Address _____ (Number, Street) Business Phone (_____) _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Employer _____ Business Address _____ (Street / City / State / Zip)

Length of time employed with above employer _____ Yrs. Business Phone (_____) _____

Name of Spouse _____ Spouse's Age _____ Business Phone (_____) _____

Spouse's Occupation _____ Business Address _____

If you are completing this form for another person, what is your relationship to that person? _____

In case of emergency, notify _____ Telephone _____

Referred by _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Pol. # _____

Insurance Co. _____ Group # _____

Insured's Employer _____

MEDICAL HISTORY

The patient's Medical and Dental History information is very important. This information bears directly on the outcome of treatment and is also important in helping to avoid complications. Thank you for taking the time to answer these questions.

1. Are you in good health? ..... Yes No

2. Has there been any change in your general health within the past year? ..... Yes No

3. My last physical examination was on _____

4. Are you now under the care of a physician? ..... Yes No
If so, what is the condition being treated? _____

5. The name and address of my physician(s) is _____

6. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
If so, what medicine(s) are you taken? _____

7. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
If so, what was the illness or problem? _____

8. Does patient have tendency to sore throats? If yes, how often? _____ Yes No
Does patient have tendency to ear aches? If yes, how often? _____ Yes No
Have Tonsils and Adenoids been removed? If yes, when? _____ Yes No
Does patient have tendency to colds? If yes, how often? _____ Yes No

9. Has patient had any injuries to the face, head or teeth? If yes, please give complete details including date(s) of occurence, nature of injury and who treated: _____ Yes No

10. Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease, scarlet fever, artificial joints? ..... Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... Yes No

1. Do you have pain in chest upon exertion? ..... Yes No

2. Are you ever short of breath after mild exercise or when lying down? ..... Yes No

3. Do your ankles swell? ..... Yes No

4. Do you have inborn heart defects? ..... Yes No

5. Do you have a cardiac pacemaker? ..... Yes No

6. Have you ever had heart surgery? ..... Yes No

c. Allergy ..... Yes No

d. Sinus trouble ..... Yes No

e. Asthma or hay fever ..... Yes No

f. Fainting spells or seizures, dizziness ..... Yes No

g.	Persistent diarrhea or recent weight loss	Yes	No
h.	Diabetes	Yes	No
i.	Hepatitis, jaundice or liver disease	Yes	No
j.	AIDS or HIV infection	Yes	No
k.	Thyroid problems	Yes	No
l.	Respiratory problems, emphysema, bronchitis, etc.	Yes	No
m.	Arthritis or painful swollen joints	Yes	No
n.	Stomach ulcer or hyperacidity	Yes	No
o.	Kidney trouble	Yes	No
p.	Tuberculosis	Yes	No
q.	Persistent cough or cough that produces blood	Yes	No
r.	Persistent swollen glands in neck	Yes	No
s.	Low blood pressure	Yes	No
t.	Sexually transmitted disease	Yes	No
u.	Epilepsy or other neurological disease	Yes	No
v.	Problems with mental health	Yes	No
w.	Cancer	Yes	No
x.	Problems with immune system	Yes	No
y.	Alcoholism or drug dependency or addiction	Yes	No
z.	Scarlet Fever	Yes	No
aa.	Chemotherapy	Yes	No
bb.	Radiation Therapy	Yes	No
cc.	Cortisone Therapy	Yes	No
dd.	Cosmetic Surgery	Yes	No
ee.	Diabetes	Yes	No
ff.	Rheumatism	Yes	No
gg.	Epilepsy	Yes	No
hh.	Chicken Pox	Yes	No
ii.	Fever Blisters	Yes	No
jj.	Glaucoma	Yes	No
kk.	Measles	Yes	No
ll.	Mumps	Yes	No
mm.	Nervousness/anxiety	Yes	No
nn.	Psychological treatment	Yes	No
oo.	Psychiatric treatment	Yes	No
pp.	Ulcers	Yes	No
11.	Have you had abnormal bleeding?	Yes	No
a.	Have you ever required a blood transfusion	Yes	No
12.	Do you have any blood disorder such as anemia, hemophilia, leukemia, sickle cell disease?	Yes	No
a.	Do you bruise easily	Yes	No
13.	Have you ever had any treatment for a tumor or growth?	Yes	No
14.	Are you allergic or have you had a reaction to:		
a.	Local anesthetics	Yes	No
b.	Penicillin or other antibiotics	Yes	No
c.	Sulfa drugs	Yes	No
d.	Barbiturates, sedatives, or sleeping pills	Yes	No
e.	Aspirin	Yes	No
f.	Iodine	Yes	No
g.	Codeine or other narcotics	Yes	No
h.	Other _____		
15.	Have you had any problems associated with any previous dental treatment?	Yes	No
	If so, explain _____		
	_____		
16.	Do you have any disease, condition, or problem not listed above that you think I should know about?	Yes	No
	If so, explain _____		
	_____		
17.	Are you wearing contact lenses?	Yes	No
18.	Are you wearing removable dental appliances?	Yes	No
Women			
19.	Are you pregnant?	Yes	No
20.	Do you have any problems associated with your menstrual period?	Yes	No
21.	Are you nursing?	Yes	No
22.	Are you taking birth control pills?	Yes	No
23.	Is there any other medical (health) information you would like us to know? If yes, please explain	Yes	No

The medical information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my health and of recent visits to my physician at my next visit. In addition, I authorize Dr. Wirtz to perform a complete orthodontic examination.

_____ _____

Date Signature

DENTAL HISTORY

GENERAL DENTAL INFORMATION

1. When was your last dental visit? _____
2. How frequently do you visit your dentist? _____
3. The name and address of my dentist is: _____
   _____
4. When was your last full mouth or panoramic series of x-rays? _____
5. Are you having any dental problems now? ..... Yes No
   If yes, please specify _____
   _____
6. I would describe my temperament as: _____
7. My hobbies or sports interests are: _____
8. Do you anticipate a move or transfer in the near future? ..... Yes No
   If yes, please explain _____
9. Are you pleased with the way your teeth look? ..... Yes No
   If no, please expain _____
10. Are your teeth discolored? ..... Yes No
11. Are you unhappy with your smile? ..... Yes No
12. Have you ever been in an auto accident? ..... Yes No
    If yes, please explain _____
    _____
13. Have you ever had an injury to your head, face, or neck? ..... Yes No
    If yes, please explain _____
14. Have you ever had teeth removed? ..... Yes No
15. Have your wisdom teeth been removed? ..... Yes No
    If yes, when and by whom? _____
16. Are you a mouth breather? ..... Yes No
17. Have you ever had a finger or thumb habit? ..... Yes No
18. Are your teeth sensitive to cold, hot or foods? ..... Yes No
19. Would you mind wearing braces? ..... Yes No
    If yes, please explain _____
20. What is your main reason for seeking orthodontic treatment? _____
    _____
21. Please specify any other reasons you have for seeking orthodontic treatment _____
    _____
    _____

ORTHODONTIC INFORMATION

1. Have you ever had orthodontic treatment (braces)? ..... Yes No
   If yes, when and by whom _____
2. Have you ever had an orthodontic examination, evaluation, conference or consultation? ..... Yes No
   If yes, when and by whom _____
3. Have you ever had orthodontic records, such as x-rays, study models or photographs? ..... Yes No
   If yes, when and by whom _____
4. Do you feel your teeth can be straighter? ..... Yes No
5. Do you feel your occlusion (bite) needs to be improved? ..... Yes No
6. Have you ever been told to see an orthodontist? ..... Yes No
   If yes, when and by whom _____

PERIODONTAL (GUM) INFORMATION

1. Do you feel your gingiva (gums) are healthy? ..... Yes No
   If no, please explain _____
2. Do your gums bleed when brushing? ..... Yes No
3. Have your gums ever bled when brushing? ..... Yes No
4. Do you regularly use dental floss or tape? ..... Yes No
   If yes, since when? _____
5. Have you ever been told that you have gum disease? ..... Yes No
   If yes, when and by whom? _____
6. Have you ever been advised to have periodontal (gum) treatment? ..... Yes No
7. Have you ever had a periodontal examination? ..... Yes No
   If yes, when and by whom? _____
8. Have you ever had periodontal (gum) treatment? ..... Yes No
   If yes, when and by whom _____
9. Will you follow instructions regarding good oral hygiene? ..... Yes No
10. Have you ever been told or have you ever noticed that your gums are receding? ..... Yes No
    If yes, please explain _____

HEAD, NECK, TMJ (JAW JOINT) INFORMATION

1. Do you feel your jaw joint is healthy? ..... Yes No
   If no, please explain _____
2. Does your jaw joint(s) click, crack, pop, grate or make any other sound(s)? ..... Yes No
   If yes, please explain _____
3. Has your jaw joint(s) ever made any of the above or other sounds? ..... Yes No
   If yes, please explain _____
4. Do you grind your teeth? ..... Yes No
5. Do you clench your teeth? ..... Yes No
6. If you are experiencing stress, do you grind your teeth? ..... Yes No
7. Do you ever have or have you ever had jaw soreness, jaw pain, muscle soreness (jaw area) neck soreness? ..... Yes No
   If yes, please explain _____
8. Do you now or have you previously experienced aches or pains in the following areas:

a. Front of the head	Yes	No	i. Side of the neck	Yes	No
b. Over the eyes	Yes	No	j. Tongue or under the tongue	Yes	No
c. Sinus area	Yes	No	k. Front of the neck	Yes	No
d. Temple area	Yes	No	l. Shoulders	Yes	No
e. Cheeks or side of the face	Yes	No	m. Upper back	Yes	No
f. Top of the head	Yes	No	n. Lower back	Yes	No
g. Back of the head	Yes	No	o. Other pain, please describe	Yes	No
h. Back of the neck	Yes	No			

   For the above problems, what circumstances seem to cause the problem(s), make it worse or make it better? _____
   a) _____
   b) _____
   c) _____
9. Do you now or have you previously experienced ear aches, ear pain, stuffiness in your ear(s), reduced hearing or loss of hearing? ..... Yes No
   If yes, please explain _____
10. Has your jaw ever "locked" open or closed? ..... Yes No
    If yes, please explain _____
11. Have you ever been told that you have a TMJ or "Jaw Joint" problem? ..... Yes No
    If yes, when and by whom _____
12. Have you ever been advised to have treatment for a TMJ or "Jaw Joint" problem? ..... Yes No
    If yes, when and by whom _____
13. Have you ever had treatment for a TMJ "Jaw Joint" problem? ..... Yes No
    If yes, when and by whom _____
14. Have you ever worn a splint or nightguard appliance for any reason? ..... Yes No
    If yes, please explain _____
15. Have you ever had a TMJ or "Jaw Joint" examination? ..... Yes No
    If yes, when and by whom _____
16. Have you ever been told that you have jaw arthritis? ..... Yes No
    If yes, when and by whom _____

The dental information provided is complete and correct to the best of my knowledge. I agree to inform this office of any change(s) in my dental health and of recent visits to the dentist at my next visit.

_____ _____
Date Signature

FOR OFFICE USE ONLY

Comments concerning medical history: _____

Significant findings: _____

Orthodontic management considerations: _____

_____ _____
(Date) Examining Dentist

Medical/Dental history update:

Date	Comments	Signature